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College of Physicians and Surgeons of San Francisco

A School of Dentistry

THE COLLEGE OF PHYSICIANS AND SURGEONS was founded in 1896, being incorporated that year, under the provisions of the Civil Code of the State of California, as an educational institution comprising the departments of medicine, dentistry and pharmacy. The first building at its present site was built in 1899 and was entirely destroyed by the San Francisco fire in April, 1906. The building was sufficiently rebuilt in time to use it for the opening day, September 17, 1906.

In 1918 the departments of medicine and pharmacy were discontinued, and since that date the College has been devoted entirely to dentistry, continuing under its corporate title in deference to alumni preference. The dean of the dental school until 1923 was Dr. Charles Boxton. Dr. Arthur Roscoe McDowell was appointed dean in 1923 and served in this capacity until his death in May 1938. The contributions made by Dr. McDowell to dental education and to the progress of dentistry on the Pacific Coast are evident by his being selected as representative of the half century of dental progress in California in the June 1950 special mid-century issue of the *Journal of the American Dental Association.*

Only Detached Dental College in America

The College was reorganized on September 1, 1923, becoming a public trust, the control being vested in a board of five trustees: three are dentists, one is a business man, and the other is the dean of the Stanford University Medical School. Plans for the College to become an integral part of Stanford University have been under way for some time. Members of the faculty of both Stanford University Medical School and the College of Physicians and Surgeons, School of Dentistry frequently collaborate on educational matters of material interest. The College is at present the only detached dental college in the United States, that is, one not an integral part of a university.

In recent years, the surgery has been completely rebuilt and modernized and the library has been moved to the main floor and is now one of the most completely up-to-date of any dental school. Maintained in addition is a "stack room," in which historical material is maintained and duplicate journals and volumes are available for exchange or requests of other libraries. Adjoining property has been recently acquired, upon which newer facilities, largely for graduate instruction in pedodontia, have been built, and in which the most modern units and chairs have been installed. Graduate instruction in this department has been an additional project in recent years.

Faculty of 150

The faculty consists of 150 members, including part and full time instructors, and five members of the Stanford University Medical faculty also serving with the dental school. Since the founding of the College, 2,013 graduates have been awarded degrees of Doctor of Dental Surgery.

In the field of research, the College has made some notable contributions to dentistry, for which members of its staff have received inter-

(Photo, Kee Coleman)

Dean Sloman

national recognition. Several graduates and faculty members are authors of accepted text books in various fields of dental education. In the organization of dentistry, graduates of the College of Physicians and Surgeons have, through its alumni, been represented at all levels, including the presidency of the American Dental Association.

The loyalty of the College's graduates is evidenced by liberal donations to the College and in the increasing activity of its fifty-two-year-old Alumni Association.

During the war years, more than 500 alumni served with the armed forces, two dying while in service, and one being killed in action in Germany. Many received decorations for outstanding service while on duty.

Dean Sloman

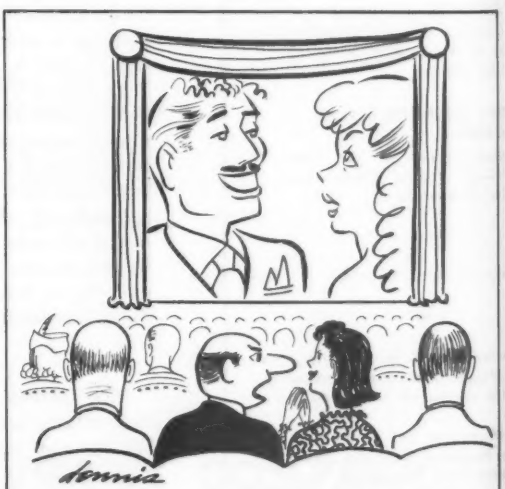
Dr. Ernest G. Sloman was appointed dean in 1938, following the death of Dr. McDowell, and after having already served continuously as a full time member of the faculty since his graduation from the College in 1921.

Appointed to the faculty upon graduation, he has been successively lecturer in operative dentistry; assistant professor; associate professor; superintendent of the infirmary; lecturer in head and neck anatomy; associate professor; professor of anatomy since 1945; comptroller of the College; and lecturer on practice management, on ethics, and on socio-economic relations in dentistry. He serves on the Stanford University faculty as lecturer in surgery (dentistry), Department of Medicine.

In the organization of dentistry, he was for a number of years secretary of the Joint Legislative Committee of the California State and Southern California State Dental Associations; and also served as chairman of the Judicial Council of the American Dental Association. For sixteen continuous years he was Recording Secretary of the San Francisco District Dental Society. He is considered an authority on all forms of social insurance in medicine and dentistry and has lectured extensively on the subject. Because of his contributions to dental education, he received the honorary degree of Doctor of Science from the University of Southern California in 1947. In January, 1949 he was elected a member of the Board of Governors of the Commonwealth Club of California.

A member of Psi Omega Fraternity, Tau Kappa Omega Honor Society, Omicron Kappa Upsilon Honorary Dental Fraternity, and the International Association for Dental Research, he became a Fellow of the American College of Dentists in 1938 and later served as a member of its Board of Regents.

Dean Sloman has had an outstanding record as writer, scientist, and educator, and is currently president-elect of the American Association of Dental Schools.



"OF COURSE HE HAS BEAUTIFUL TEETH — I MADE THEM FOR HIM!"

Vertical Dimensions with Compatible Function

By JOHN D. LOGAN, D.D.S.

FOR more than a hundred and fifty years dentists have been groping in the dark for a solution of one of the most important phases of denture prosthesis – that of correct vertical dimension.

And still, at this late day, patients are suffering, alveolar ridges being crucified and dentures discarded through the erroneous theory that the physiological rest position remains the same from infancy to old age.

There is only one vertical dimension and that is the habitual and accustomed position of the jaw relation at the time of denture construction and insertion – and not what it had been.

To make this more impressive and show what an error in dimensional jaw relation can engender, it will be necessary for me to relate one of my many experiences.

One Sunday morning, a number of years ago, my telephone rang. It was an out-of-town call from a physician. He asked me if I would see his father-in-law, who was having trouble with dentures and wanted me to examine his mouth and see if anything could be done for him. They appeared at my office that afternoon, and I examined the older gentleman's mouth and took his history.

Fourteen Denture Failures

His teeth had been extracted nine years before and he had dentures made but could not wear them. Since then he had thirteen more made, fourteen sets in all, with the same result. He said he could not eat with any of them on account of soreness. Besides the inconvenience and discomfort, it was embarrassing to him, as he was an industrial executive and had to attend many meetings and functions where food was served, but had to refrain from eating. The younger man said his father-in-law was sixty-four years of age, had spent five thousand dollars on his mouth, was badly discouraged and fearful that nothing could be done for him. I told him I thought something could be and, if I were mistaken, there would be no fee.

In brief, I made the dentures, serviced them twice, remade the lower ten years afterward, and he wore them until he died at the age of eighty, sixteen years later. (They were vulcanite.)

Now, why all these fourteen failures? Many of these men were expert denture men, but they failed because of two reasons: first, their disregard of gerontology; and second, following the erroneous but accepted method of the physiological rest space to determine vertical dimension.

The patient referred to above had all the evidence of the degenerative processes incident to age and living too well, and his tissues would not permit, nor could they endure, the load nor abuse that might have been tolerated were he young and vigorous. Overload was nevertheless forced upon him and, of course, it resulted in failure.

The natural denture can take a stress of sixty and, in extreme cases, up to three hundred pounds. So to force one half of this poundage on a mucosa that is not only low in cell activity but lying between a hard denture base and a hard corticle plate of bone and expect it to carry this poundage is not logical to me. Besides, I see no absolute necessity for it as most American food needs but from ten to fifteen pounds in a denture bite, and a tough steak can be made into a hamburger. At any rate, no reasonable person would expect a prosthetic substitute to duplicate in function the natural dentition. It has been my experience, where the patient is young and healthy and given a heavy bite, tenderness soon compels him to react to a more cautious and gentle bite, like a child on a sore tooth, but aged patients are not so adept in this acquisition.

A Case History

Now the error in depending on the physiological rest space to determine the vertical dimension can readily be exposed in the case history of this patient with the many dentures.

It revealed that he had been an inveterate tobacco chewer. His teeth, or what was left before he had them extracted, were abraded to the gum margin, and, of course, he was forced and had followed through from the beginning of the abrasion, to come into occlusal contact in mastication and swallowing. This not only became an accustomed habit but the muscles of mastication contracted to conform to it, as the tactile sense is the signal for exerted force in mastication. We can assume that he originally had ten millimeters of tooth crown on the uppers and ten millimeters of crown on the lowers. This, when added to the approximate three millimeters of physiological rest space, and allowing two millimeters for ridge absorption above and below, would constitute an overall opening of twenty-seven millimeters. The denture space, less the free-way space, would be twenty-four millimeters to bring him back to his original vertical dimension before abrasion of his teeth took place. Assuming that he abraded eight millimeters of tooth structure from the upper and a like amount from the lower, his bite would have become closed sixteen millimeters from the original vertical dimension and point of physiological rest space.

The abrasion that gradually closed the bite pursued its course for years; the contraction of the muscles followed through, the tactile sense that gives stimuli to the masticatory muscles for the exertion of force followed through, and so did contact position of the teeth for swallowing. His jaw became accustomed and, of course, habitual in arriving at this position which was always anticipated by acquired reflexes. The change in vertical dimension threw his whole masticatory apparatus out of harmony and increased his biting force beyond its accustomed and habitual stress. From the foregoing you see that this patient's happy and comfortable masticating and swallowing contact position of the jaw was sixteen millimeters closed from the physiological rest position. Reference to the physiological rest position is no criterion in arriving at the habitual vertical dimension. You cannot, with comfort, change habit or stretch muscle in the aged. It is the swallowing contact position and not the physiological rest position that will determine for you how high to build, and if you go beyond that for esthetics you are gambling with success.

Determining the Swallowing Contact Position

You will want to know how I arrived at this swallowing contact position and its significance relative to the accustomed bite. Well, an automobile manufacturer has a slogan, "Ask the man who owns one"; and I happen to be the "man who owns one," dentures that is, and have experienced, with all five senses, the behavior of which brought about and proved my conclusions. Everybody swallows from five hundred to seven hundred times in twenty-four hours, and each time he does he contacts his teeth. If there are no teeth there to contact, he puts his tongue between the ridges for a contact position which acts as a fulcrum for swallowing. There is also some stress exerted on the tongue or teeth when this swallowing reflex takes place. Though this stress is not great, it will vary and increase or decrease with the variations in vertical dimensions. In a case where dentures have been worn for a long period of time and absorption has progressed to the extent that the dentures have settled beyond the swallowing contact position, the patient will put his tongue between the occlusal surfaces of the teeth when swallowing, to get the accustomed contact fulcrum position. And where the bite is opened beyond this contact position, the jaw will often exert terrific force in its endeavour to force its way back to this position. It is this continuous force, added to the increased masticatory force, that causes the soreness, and not the force of mastication alone, as is claimed. The force of mastication is only exercised for three short periods a day and the cells have a chance to build up. But the force exerted in swallowing is almost continuous, especially if the bite is opened beyond the accustomed swallowing position and there is very little time for cellular reconstruction. Hence, destruction of tissue ensues. Nature will tolerate

"AFTER THE DOCTOR GAVE HIMSELF A NEEDLE, JUNIOR HARDLY BOTHERED HIM AT ALL."

considerable force on the mucosa intermittently, but not a too continuous force.

To find this swallowing contact position, we have worked out this method and, considering the variables in the human equation, we have found it quite satisfactory. A little practice is required at first, but otherwise it is quite simple. After you have made your upper base-plate on which you have put a hard wax rim and shaped it to the high and low lip line and occlusal plane, make your lower base-plate and put on it a compound rim approximately eighteen millimeters high from muco-labial fold. Sharpen this compound rim so that on cross-section it would look like a wedge. Then insert the upper bite rim into the mouth; then soften the sharp surface of compound of the lower rim to the depth of about two millimeters and insert it into the mouth; have a bulb syringe ready and inject a few drops of water on the tongue and tell the patient to swallow. This will give you an adaptable occlusal plane on the lower. Now take both bite rims out and on the upper put a flat strip of equalizing wax (which is quite soft) all around the occlusal surface of the rim. Next, sharpen again the lower compound rim, and with your syringe ready put the lower in the mouth, inject on the tongue several drops of water, and tell the patient to swallow immediately. Take both rims out and examine the equalizing wax on the upper. If the lower compound knife-blade rim has penetrated through the wax, you are open too much. In that case, cut off or reduce the compound rim two millimeters and sharpen it again, and peel off the equalizing wax from the upper rim and put on a new strip. Then insert upper and lower rims in the mouth again, inject water. Tell the patient to swallow; remove both rims from the mouth and, if the lower compound rim has indented the wax on the upper rim not more than a half millimeter, cool it and insert both upper and lower rims in the mouth again; inject water, and have the patient swallow again. (In some cases it is necessary to do this several times to be sure.) If the patient in swallowing does not indent the equalizing wax on the upper rim any deeper than one half millimeter, you have a safe swallowing contact position, and the best vertical dimension for comfort. But if the penetration is deep, you will likely encounter trouble with soreness and necessary adjustments. Assuming that you have used the face-bow in mounting the upper cast on the articulator, put the lower rim into the indentation on the upper wax and put plaster around them both to keep them together while mounting the lower cast on the instrument. Then set the incisal guide pin to hold what is now the vertical dimension. Since this is not centric bite, set the graph plate of the gothic arch tracing table on the lower and the gothic arch tracing pin on the upper, insert them in the mouth and make the tracing, lute them with plaster, and take them out of the mouth. Remove the lower cast from its ring and remount on the instrument with incisal guide pin in position. This is now the correct centric relation and comfortable vertical dimension. From here on you can use the method of choice for lateral and protusive relation.

Cautions

Here are some cautions: Don't tell the patient, at any time previous to this procedure, to close or bite. The patient must be in perfect ignorance of what your intention is, else he will close or bite and fool you. This procedure must be a purely unconscious reflex.

Bear in mind that there is a definite position to which the jaw will go to contact the teeth for a fulcrum in the reflex act of swallowing and it becomes accustomed and habitual, and very little force is exerted. If the bite is closed beyond this position, the tongue will act as a wedge for the teeth to rest on to fill the gap. If the bite is opened beyond this position and the teeth contact before the anticipated arrival, there will be terrific force exerted by the muscles of mastication, varying in the intensity to the size of the gap. But worse, since it is an unconscious reflex, it becomes more continuous than normal and intolerable to the mucosa.

It is this position of contact where the tactile sense gives stimuli to the muscles to exert force. If the tactile sense is light, so is the force; if the tactile sense is heavy, so is the force, and the jaw will continue this force in its endeavour to force its way back to the accustomed and habitual position. So let us register jaw relation in this habitual position, and not try to strain muscle and the patient's habits.

There is too much standardization in denture prosthesis – we cannot pursue the same course with the aged as we can with youth. The aged do not bend readily to the change of habit nor the strain of muscle, nor are the reparative processes so active. They are prone to be irritable and impatient, for most of the joys of life have departed, and we are called upon to restore what is, perhaps, the last vestige of pleasure – that of eating. Let us not fail them!

America's Number-One Killer from Mouth Infection

By CHARLES A. LEVINSON, D.M.D.

HEART disease is still the number-one killer of adults in this country. Hardly a week passes but we learn of the sudden death of a relative, friend, or an acquaintance. Most of them were between forty and fifty – just in the prime of life.

We bewail their loss, and wonder why they went so suddenly. It must be the fast pace at which we are living. This atomic age is burning us up so fast. Or we might infer it was worry and anxiety that brought about their abrupt deaths. No, I am afraid this kind of introspection is very far from the real truth of this important matter.

One of the most important causes of heart disease is focal infection. This infection may originate in the teeth, intestines, tonsils, or in any part of the body.

About three decades ago the late Sir William Hunter, famous English physician, first discovered the focal infection theory. He believed that most systemic diseases in the human body originated in infections from the three T's – teeth, tonsils, and intestines. This theory is still adhered to by some medical and dental practitioners.

Dental disease has an incidence in this country of something like 95 per cent. The two predominating diseases of the mouth are abscesses and pyorrhea.

The average person with a heart condition is more likely to be seen by his dentist before he consults his physician with marked symptoms of this number-one killer.

One of the germs which may originate in an infected mouth and give rise to heart disease is known by the jaw-breaking term of *Streptococcus viridans*. Under the microscope they appear as short chain organisms. They are very deadly once they get into the blood stream. These "bugs" are constantly present in the mouths of not only individuals with mouth disease but also in the mouths of healthy individuals. Even those who exercise the greatest care in cleansing their mouths have these germs present. This type of germ is only one of a myriad which invade the body and bring about health destruction.

When these organisms gain access to the blood stream from a focal infection, such as teeth abscesses or pyorrhea, they are carried to all parts of the body.

In many cases when these germs are disseminated throughout the body the diseased action is manifest in one localized part of the body, and this will give rise to such conditions as endocarditis (a form of heart disease), arthritis, neuritis, and so forth.

Very often clearing up of the focal infections – such as removal of abscessed or pyorrheal teeth, or gum infection – leads to the disappearance of all symptoms.

The use of penicillin must be exercised by the dentist during the dental surgery procedure. This definitely prevents the spread of bacteria from the area of dental infection during treatment, thus preventing the infection from entering the general blood stream. The area of infection must be localized by this drug.

In those known cases of heart disease, the dentist should inform the patient's physician, who will advise the patient to receive penicillin by intramuscular method or by mouth. This penicillin treatment by the physician should be supplemented, simultaneously, when the patient is undergoing dental surgery, in order to remove any sources of foci of infection from the oral cavity as well as the general blood stream.

These penicillin treatments by both the physician and dentist should bring about a better relationship between the two professions, thus acting as a double bulwark to save those unfortunate individuals who are afflicted with America's number-one killer from mouth infection.

I wonder how many persons have fallen victims to an early death because of this sadly neglected practice, which should be more emphasized in the daily practice of both physicians and dentists. I have been practising dentistry for the past twenty-seven years and I rarely see or learn of a close medico-dental relationship.

The physician in his examination and check-up of his patients goes one way and the dentist in his work goes the other way.

When I entered Harvard in 1919 I was taught that dentistry was a branch of medicine. I hardly see the marked relationship there should be. This relationship of physician and dentist is more prevalent in hospitals and clinics. But it is sadly neglected in the office of the average medical and dental practitioners.

If and when a patient appears at his dentist's office and X-rays reveal mouth or gum infections, such as pyorrhea, abscesses, gingivitis, and so forth, the patient should be referred immediately to his physician or a hospital for a complete systemic check-up. Particular emphasis must be brought to bear on the heart examination.

Similarly, if a person with a heart condition consults his physician, the medical doctor should immediately refer the patient to his dentist or to a clinic for full mouth X-rays and clinical examinations of his mouth. In this way all sources of "focal infections" would be cleared up on removal of all infection sources. Thus the systemic or heart condition would improve, and the patient would add longevity to his life.

Dentistry and medicine must extend welcoming hands to each other if we are to eradicate America's number-one killer, heart disease. Closer cooperation of the two healing arts will help greatly to save many lives which, otherwise, will be lost.

Twenty Questions and Answers

1. Do people under 40 get heart disease?

YES. People of any age may have diseases of the heart or blood vessels.

2. Are there many kinds of heart disease?

YES. The 6 common kinds are:

Congenital heart disease (some babies are born with defective hearts)

Rheumatic heart disease (along with rheumatic fever, causes more deaths than any other disease among children of school age)

Subacute bacterial endocarditis (most likely to occur between the ages of 15 and 35 years)

Cardiovascular syphilis (usually becomes evident in middle age)

Hypertensive heart disease (most common in middle age)

Coronary heart disease (may begin in middle age – most common in older individuals)

3. Are women the weaker sex so far as getting coronary heart disease is concerned?

NO. Fewer women than men get coronary heart disease.

4. Do most people who have a heart disease die suddenly?

NO. In most types of heart disease, death, when it comes, is not sudden. Many sudden deaths are wrongly blamed on heart disease.

5. Is high blood pressure common below the age of 50?

YES. The most serious form occurs in people under 50.

6. If your heart sometimes skips a beat, is this a positive sign of heart disease?

NO. Many a person with a normal heart may sometimes feel his heart skipping a beat or beating faster or slower than usual. However, it *may* be a sign of heart disease. In your own case, ask your doctor.

7. Do more people die of heart disease than of of any other cause?

YES. In the United States more people die of diseases of the heart and blood vessels than of any other cause.

8. Should a person's blood pressure be about the same when he is 50 as when he is 30?

YES. No significant rise in blood pressure occurs with age. However, it is normal for your blood pressure to vary with your activities and emotions.

9. If a baby is born with a defective heart, can anything ever be done to remedy the defect?

YES. Often surgery can help or cure the child. See your doctor.

10. Is it possible to have a heart murmur without having heart disease?

YES. Some people with perfectly good hearts have slight murmurs. Your doctor will tell you when a murmur is a sign of heart disease.

11. Can teachers do anything specific to fight heart disease?

YES. If the teacher knows what symptoms suggest that a child is under par, she can report children in poor health to the school nurse or physician. This is a method for finding cases of rheumatic fever and rheumatic heart disease.

12. Is rheumatic fever contagious?

NO. But certain types of streptococcus infection prepare the ground for rheumatic fever. Such streptococcus infections are contagious.

13. Should employers refuse to hire people who are known to have heart disease?

NO. If the employer checks with a physician to make sure that the employee with heart disease can work at a particular job, there is no special risk.

14. Do scientists now know all the causes of heart disease?

NO. But public support of the American Heart Association and its affiliates now makes it possible for scientists and physicians to learn more about diseases of the heart and circulation.

15. If you get short of breath after climbing a flight of stairs, is this a positive sign of heart disease?

NO. While shortness of breath *may* be a sign of heart disease, there are many other troubles that can cause this symptom. If you have this symptom, see your doctor.

16. When a person has coronary thrombosis, must he be an invalid for the rest of his life?

NO. Many patients recover completely.

17. Is a pain in the left side of the chest a positive sign of heart disease?

NO. A pain in the left side of the chest is usually *not* due to heart disease, but should be checked by your physician.

18. Does susceptibility to rheumatic fever tend to run in the family?

YES. When one case of rheumatic fever is discovered, other members of the family should be examined.

19. Should people with heart disease take special care not to become overweight?

YES. Overweight puts an extra strain on the heart.

20. Do you know what services there are in your community for people with heart disease?

If your answer is "yes," award yourself a medal of merit—but don't stop there. Work with your local Heart Association to:

a) let others know what help is available.

b) improve and extend present services for people with heart diseases.

One Will Get You Ten

By HARRY PEAKE, L.D.S., D.D.S.

THAT'S fair odds in any man's language. But in this case we're talking of smiles, not the folding stuff.

If I were to be asked what is the greatest need of the dental profession today, I would say it is the ability to laugh. Not to laugh at somebody else, but to laugh at ourselves. True, when one of our buddies sidles up and says out of the corner of his mouth: "Have you heard the one about the farmer's daughter?" we start to pucker up right away. But how many of us have learned the priceless art of being able to see the funny side of our own actions?

A laugh—or a smile—is one of the most powerful forces on earth. And it is the one thing which will make the day run smoothly in a dental office.

One morning a nondescript little patient I had never seen before came into my office without an appointment. The Skipper was off duty, so I went out to the reception room to see who in heck was bothering me when I was rushed off my feet.

When he told me he wanted a tooth out, I made a sharp answer about the need for an appointment. He looked at me and *grinned*. "Gosh, Doc," he said, "you fly off easy."

What happened? You guessed it. I cut another appointment short so I could take him. And I had a laugh up my sleeve at my own expense for the way he got around me.

Had that smile not appeared on his lips, I would have refused him in an abrupt manner. He would have gone out feeling angry at such treatment. I would have been angry at him for trying to crash in when I was busy, and annoyed with myself for showing my anger. That would have kept gnawing at my subconscious for the rest of the day, and nine chances to one would have produced a headache.

As it was, he made another appointment, and turned out to be a full denture case.

One day the office phone rang. When the Skipper answered, an elderly female voice inquired: "Can you tell me where I can find the dentist who makes plates?"

The Skipper informed her that we did denture work, but that was not what she wanted. "Oh, no," she said. "I want the dentist who doesn't do anything else but make plates. He does them cheap."

The Skipper politely told her we didn't know anything about that "dentist," and hung up. Then she gave me the other side of that conversation and we both had a good laugh. The idea of a person calling a dental office to ask where she might get in touch with a lab technician who was doing some denture bootlegging struck us as being decidedly funny. Later, when it wouldn't affect the pressure of our circulatory system one way or other, we might inform the proper authorities. But why spend a lot of time yammering "we was robbed" when our own peace of mind was all that would be influenced?

I often think of an incident in the biology lab while still in college. One of the boys with a flair for practical joking slipped the gory remains of a dissected frog in a classmate's pocket. He spent some time whispering the news of his accomplishment and laughing at the expense of the innocent victim. Then, just by chance, he happened to put his hand in his own pocket — and encountered some of the same. Did he laugh then? You can take it from me he didn't.

Playing practical jokes does not mean the possession of a sense of humor. It is, more often than not, an outlet for an inferiority complex.

Learn to laugh *with* patients, not *at* them. And I don't mean to laugh with them at the expense of some third party who is not present. It's amazing how fast the grapevine works, and while the person who shares the laugh with you might get a lot of enjoyment out of it, he might also trot right off to tell the victim of your humor.

Many patients come into a dental office with fear, and they appreciate a bit of free and easy humor to loosen the tension of their nerves. But there are also times when it is not wise to make with the yak-yak. Some patients seem to get a morbid pleasure out of having their troubles magnified. One must use judgment.

One afternoon I took a call from a new patient whose voice sounded as taut as a banjo string even over the telephone. "Can you tell me what to do for a toothache?" she asked.

I took a chance. "Have you got a monkey wrench in the tool box out there?" I queried. (I might have asked her what she thought dental offices were for, but I didn't.)

"A monkey wrench?" There was surprise in her voice. Then she started to laugh. The trick had worked.

I told her to leave the wrench where it was and get right to the office. She did, and when she came highballing into the operating room a short time later her tension was practically gone.

Of course, it was a chance. Had she been the other type of patient who wants to be told how sick she is, she would have hung up on me and called another office. In that case, she would have been better pleased — and so would I. I like my office to be a cheerful place, and have no time for decorating it with crepe to suit the moods of hypochondriacs. If I can help them, fine. But if they're the dyed-in-the-wool type who are past all earthly aid, I don't want to have to dip down to their level. That alters the atmosphere of my office, and has its effect on other patients.

One of the highest compliments paid me since coming to these parts was when I was asked to visit a certain summer resort. "You'll like it," I was told. "Only *characters* go there."

That lady complimented me by calling me a character. In her language a character is one who refuses to go with the herd simply because some old bull moose takes it into his head to mooch off in a certain direction.

It is only necessary to read the contemporary magazines to realize that nervous disorders are one of the main problems of the present day. Worry is the bugbear of our generation — and one of the best antidotes for worry is cheerfulness. See all the fun there is in life. And try to make other people see it too. There's a funny side in almost every situation. Look for it. Pass it on. Don't let the serious angle swamp you before that laugh gets to the surface.

Some folks can see the funny side easier than others, it may be argued. But if anyone thinks I am one of those overly plump, easy-going creatures, please be disillusioned. With a grandparent boasting the name of Monaghan, I don't take kindly to anyone treading on the tail of my coat. However, as the years have piled up until their weight has worn all the hair off the top of my head, I have acquired a reasonable facsimile for a sense of humor. I can now laugh at most things except tax collectors and traffic cops. When that stage has been reached, I shall apply for my halo and cease striving.

"Duet." Red iron wood.

Left, "Displaced person"; maple wood. Right, "Salome and John the Baptist"; birchwood.

Rx *for Living*

DENTIST SAMUEL GERBER—WOOD SCULPTOR

By JOSEPH GEORGE STRACK

WHILE dining at an inn one evening, a man saw a waiter carrying a log to the fireplace. The natural formation of the chunk of elm interested the diner. He had the waiter put the log in his car.

From that piece of elm was carved a sculpture called "All Is Vanity." It is a figure of a swan with a crown on its skull. The swan symbolizes the aspirations of man; the crown represents the realization of those dreams; and the skull, of course, means mortality. In theme and in powerful projection of theme, that piece of sculpture is reminiscent of the famous painting of the same name in which a beautiful woman looks into a mirror and sees her death's-head reflected there.

The diner at that inn who visualized the artistic possibilities of a log was Samuel Gerber, dentist and sculptor.

Dr. Gerber has a magnificent obsession—wood sculpture. He has raised the whittling of the idler to the sculpturing of the artist. When he takes a week-end leave of his dental office at 274 Madison Avenue, New York, he goes to his summer retreat in Ridgefield, Connecticut, and devotes himself to fine art.

Adjoining his home is a specially-built, screened-in studio. It is filled with wood, ebony, and alabaster figures, but most of his sculptures have been carved from the wood of Fairfield County trees. Many of his friends and neighbors in Ridgefield have learned to be on the alert for odd-shaped blocks of wood, and they send such pieces to him. Every time a tree is cut down, Dr. Gerber is sure to get a telephoned invitation to see if he can "do anything with it." One of his pieces, "The Woman," which was recently exhibited at

Norwalk under the auspices of the Silvermine Guild of Artists, was carved out of a pear tree given him by a neighbor. The bark and the shape of an apple tree donated by another neighbor suggested two unique sculptures, "Drifting" and "Skater."

Sought Professional Guidance

Dr. Gerber has been sculpturing for three decades. He started when he was a young practitioner and had much time and few patients. "I began to play with clay," he explains, "idly fashioning it into whatever form came into my mind. One day I moulded a head, that of my little girl. It happened to be a reasonably good effort, and I became interested in sculpturing. I tried a self-portrait of myself in clay. Friends whose opinions I respect thought it was worthwhile. So I sought professional guidance. I studied first with Genevieve Hamlin, who taught woodcarving and stone cutting. Then I worked with Archipenko, and with Chaim Gross, one of the masters of sculpture in America."

The Gerber studio is located a short distance from the main house. The studio holds some power-driven machinery, such as band saws, planers, and a sander. Here, isolated from the everyday tasks of life, Dr. Gerber devotes himself to his art. "The bridge from ordinary whittling to wood sculpture is a short one for the individual with creative ability," he says. "It is a matter of time, experience, purpose, and concept. As everyone knows, one of the oldest recipes for relaxation is carving wood, keeping the hands busy and concentrating on the final shape the wood is to take. For centuries people have engaged in such 'therapy' almost instinctively. Today it is recognized as a sound therapeutic procedure. I find it especially satisfying because it represents not only an easy, fascinating form of recreation but offers, as well, the means of expressing oneself creatively. Thus, to the intellectual or creative individual who might regard mere whittling as a negative 'pastime', that is, a waste of time, wood carving on a creative level offers the opportunity to use and integrate both manual and artistic skills with purposeful and fruitful objectives."

Sculpture is not the only art practiced in the Gerber family. All the other members of the family – Mrs. Gerber, a son, and a daughter – are musicians. Mrs. Gerber, a former scholarship student at the New York School of Music, is a violinist. She has organized a string quartet in Ridgefield, and has sponsored musicales there. Mrs. Paul Bernard, the daughter, is an accom-

Self-portrait in clay.

"Music," an alabaster bas-relief.

The dentist-sculptor and his grandson.

plished pianist, and the wife of the concertmaster of the Connecticut Symphony Orchestra. The son, Dr. Irving A. Gerber, who is associated with his father in dental practice in New York, is a well-known amateur cellist.

Founding An Art Colony

With this background of music and art in the family, the elder Dr. Gerber's interest in founding an art colony in Ridgefield to promote opportunities for impoverished artists seems to be a natural one. "My friends in Ridgefield and I want to develop an art foundation to build a place where poor artists could spend at least a two-week's vacation each year," he explains. "All of us have some dream project or other – or should have – and this art foundation is mine. I admit I am 'hipped' about it, but all of us should have some pet project about which we can be 'hipped'. An interest of this kind, especially when it stems from altruistic motives, is a source of amazing zest, energy, and constructive effort. It gives one 'a new lease on life,' and adds color and content to one's everyday existence."

Dr. Gerber has a wholesome regard for professional artists. He will not, for example, sell any of his sculpture. "We live in a commercial economy in which artists must compete, as must everyone else, in the market place. They depend on sales for a living, and I will not add to that heavy competition. I am a dentist by profession, and I look to dentistry for my living."

An American-in-the-Making

Born in Bucharest, Romania, sixty-four years ago, Samuel Gerber came to America when he was fifteen years old. His first job was in an incandescent mantle factory. Next he found work as an office boy in a dentist's office. He learned all he could about "mechanical dentistry," and attended night school. He entered the New York College of Dentistry, and was graduated in 1907 with honors.

"America has been good to me, as it has been good to all other Americans," he says. "It has given me the opportunity to qualify for, and to practice, a profession – dentistry. It has also made it possible for me to develop whatever artistic talents I might have, to realize my individuality, to live a full life. No society can do more than make such opportunities possible. It is up to the individual to recognize and use these opportunities. It is also the responsibility of each one of us, I believe, to help make such opportunities possible for others. I propose to do this through an art foundation. In this small way I hope I can make my contribution to the American way of life."

"WELL, IF YOU DON'T GIVE ME A QUARTER, DAD, I'LL PROBABLY WALK OUT GROANING – AND YOU KNOW WHAT PEOPLE WILL THINK."

A Dentist Reaches for the Stars

By ARTHUR J. BURKS

IN 1938 Herbert K. Cooper, D.D.S., D.Sc., F.A.C.D., founded the nonprofit organization now known as the Lancaster Cleft Palate Clinic, 26 North Lime Street, Lancaster, Pennsylvania. He believed that cleft palate and cleft lip were primarily dental problems. He suspected that every cleft palate, cleft lip person was automatically maladjusted, eternally cringing from his day to day "situation." He knew that while dental work must invariably be *first*, certain technical skills were required of a clinic which a dentist could not supply. He had to sell others on his dream. He needed speech therapists, psychologists, plastic surgeons, orthodontists, otologists, physicians, radiodontists, pediatricians, dental hygienists, dental consultants, and perhaps more that he could not foresee.

From the beginning it was his belief, now thoroughly proved by twelve years of experience, that only by treating *the whole person* — dentally, medically, emotionally, psychologically, spiritually — could the cleft palate cripple be reclaimed for useful citizenship.

Dr. Cooper continued his private dental practice, a fortunate thing as far as the clinic is concerned, for he has had to provide an average of $6,000 a year to make up clinic deficits, though nominally he is *supposed* to have a salary, as director, of $3,000 a year. He has never received it or regretted not receiving it. He hopes only that other dentists, around the world, may find it in themselves to do as he has done, doing it better if possible. A modest man, he is sure it is possible.

1,000 Patients Helped

Staff members came and went during the first twelve years of the clinic's existence. Something over 1,000 cleft palate persons have been examined or treated and helped "over the hill," Cooper's way of saying they have been reclaimed. Men and women who couldn't even ask for jobs have now become lecturers, lawyers, foremen in factories, dental technicians, and *speech consultants!*

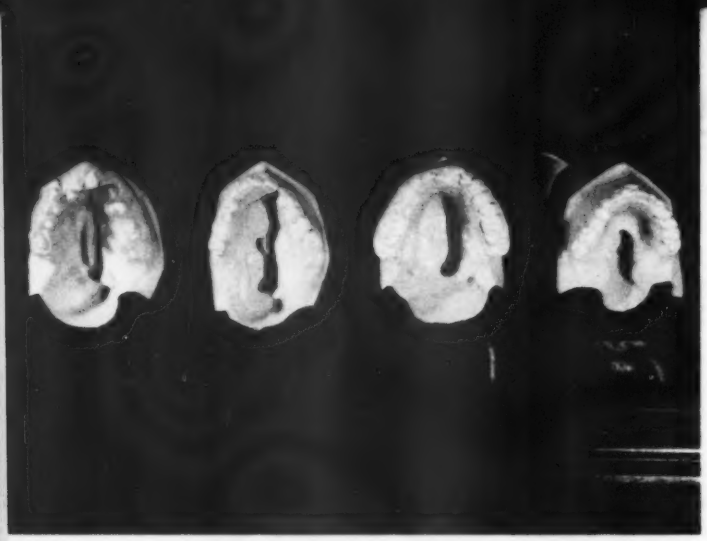
Currently, Dr. Cooper's staff consists of the following:

Mrs. Kathryn Cushman, Cooper's secretary, aggressive "Central Control" of the entire clinic (presides over staff meetings, and is the only lay person, aside from the janitor, Charles A. Jameson);

S. June Smith, Ed.D., psychologist; Genevieve M. Diller, M.Ed., speech clinician; Toylee M. Snyder, speech clinician; Eleanor M. Hallman, D.D.S., orthodontist; Ross E. Long, D.D.S., orthodontist; Arbuta Wagner, R.D.H., dental hygienist; Leroy M. Ennis, D.D.S., F.A.C.D., consulting radiodontist; Maurice P. Gross, dental technician; Irvin H. Uhler, D.D.S., oral surgeon; Robert H. Ivy, M.D., D.D.S., F.A.C.S., plastic surgeon; Lawrence Curtis, M.D., D.D.S., F.A.C.S., plastic surgeon; David B. Coursin, M.D., F.A.A.P., pediatrician; Carl C. Kessler, M.D., clinician physician; Herbert K. Cooper, Jr., M.D., clinician physician; Paul E. Bomberger, D.D.S., F.A.C.D., dental consultant; Charles S. Gaige, D.D.S., dental consultant; and Lloyd S. Hutchinson, M.D., otologist.

Cooper has learned that even the best intentioned people who have special skills are likely to feel that their skills are the most important to any team effort. The team job of getting a maladjusted cleft palate cripple "over the hill" has repeatedly proved that this just isn't so. Every skill is needed, to the limit. But Kathryn Cushman, utterly without prejudice, cracks the whip when the staff gets together at the end of the

Drs. Hallman, Cooper, and Coursin and technician Gross planning treatment. An appliance for restoring facial contour is being constructed.



Some general types of cleft palate: Cleft palate, soft palate only; cleft of soft and hard palate; cleft of soft and hard palates, one side usually affecting lip, producing cleft lip; soft, hard, and going through lips, producing double cleft of lip.

clinical day to compare notes on the day's cases. She knows that Dr. Cooper desires and intends that patients shall, after weeks or months – usually months – leave the clinic as nearly normal human beings as clinic improvements on Nature's carelessness can make them. One person in seven hundred, approximately, is born with cleft palate, cleft lip, or both. There are approximately 200,000 such persons in the United States.

Clearly, there is work for other dentists who are as capable as Dr. Cooper and his associates are of absorbed self-dedication to an inspiring task.

How the Clinic Operates

After Kathryn Cushman has asked questions about the financial status of an applicant (who can be accepted even if he hasn't a penny, but couldn't *buy* his way in with a million dollars) and filled in some detail of a lengthy questionnaire, S. June Smith takes over. She conducts the intelligence tests, including the Rorshach ink blot test, often finding patients to be far superior to what parents, associates, schoolmates, and teachers believed (one "near-moron" tested 126 recently!). After which Dr. Cooper himself makes the oral examination, invariably finding supernumerary or misplaced teeth.

Dr. Cooper often precedes Kathryn Cushman in meeting newcomers of all ages. He opens his arms wide to everyone. By the time they get past Mrs. Cushman and Dr. Cooper, they know they are, perhaps for the first time, being treated with decency, respect, and sympathy. The most sullen begins to smile – and Cooper and his associates know that victory is possible.

If the medical examination shows that medical treatment should precede treatment for cleft palate and harelip, that treatment begins at once, either under the clinic physicians or the family physician, or cooperatively under both.

Preliminary examination often indicates hearing loss, which associates in the past may have regarded as "sullenness," and this loss is measured and corrected under the supervision of the clinic otologist.

Under the alert eyes and ears of Genevieve Diller and Toylee Snyder, patients' speech is recorded, and played back so that the patients can hear themselves as others do. Within six months their speech is again recorded and played back; this after every possible psychological and mechanical help has been rendered; after, especially, the speech appliance, fashioned to replace the palate left out when the patient was born – nobody knows why – has been made and the patient has become accustomed to it. The letters d, m, k, g, s, t and the sound ch, hitherto beyond the patient entirely, have now been artificially mastered. To accent the improvement, the second recording is on the same platter as the first, so the patient can hear just how far he has traveled.

No small part of the way the patient has improved has been the work of Genevieve Diller and Toylee Snyder, who concern themselves with speech – and therefore emotional and social

Typical cleft of soft and hard palates, affecting also the lip. Se performed on the lip. Appliance is shown in. (See photo cle

– retraining. Training is a group effort. Patients are taught from the first to face the facts of their "difference" from other people, and to join hands in overcoming it. Patients who can do some one small thing better than the others, help to teach. The speech clinicians have the patients stick out their tongues. They study the tongues, begin teaching the patients how to roll around those fearsome sounds that have been insurmountable shibboleths. The patients are taught to hum, to drink through straws, even to spit – things they have not been able to do. They discover that they can even sing. Of course, not everything can be done until some start is made on the building of the speech appliance, and the "bulb" that takes the place of the uvula. In a given group there are usually some who have spent more time than others in the clinic, whose appliances are approaching completion. These persons inspire newcomers, who are encouraged to keep on going until they, too, have mastered their oral mountains.

The All-Important Appliance

The job of building the appliances, which are as individual as people, teeth, and fingerprints, is in the hands of the orthodontists, Drs. Hallman and Long; the dental hygienist, Miss Wagner; the dental technician, Mr. Gross; *and* Kathryn Cushman and Dr. Cooper, the former to keep things moving on schedule, the latter to make sure that nothing is overlooked. The speech appliance, on which so much depends, must come as close to taking the place of the palate – whatever part of it the Creator left out – as human hands and wisdom can make it. If it fails, the treatment fails. Accustoming the patient to the appliance is as much a part of the treatment – and akin to it – as the task, shared by all, of correcting maladjustment. This correction, by the way, extends even to the patient's family, associates, schoolmates, and teachers, among whom most of it is born. Cooper doesn't hesitate to take to task any associate who may contribute to a patient's maladjustment – such as schoolmates, for example, who laugh at the almost unintelligible cleft palate cripple, and parents who may regard the cleft palate son or daughter as a "burden and a trial."

Patients live at the clinic during treatment, if possible. Jobs are found for some in carefully selected homes, in which they may see how harmonious families live and profit from observation.

Close-up view of the appliance.

Almost an Exact Science

Some patients have been orally mutilated by previous "treatments," and mutilations must be corrected – though these sometimes pose almost insoluble problems. Labial surgery is needed on some, and the younger the patient the better. One of the prized possessions of the clinic is a motion picture depicting Dr. Ivy, the plastic surgeon, performing a delicate operation on a three weeks' old girl whose cleft lip was more extensive than the average. The detail work must be amazing, even to a surgeon. Dr. Ivy seems to unfold the malformed curves of the cleft, layer by layer, mortising the layers together across the cleft, closing it with grafting. The final frames of the movie show the child six weeks after the operation, *smiling*. The smile pays the squeamish viewer, and must have been a high reward to the parents of the child. This particular child, treated so young, will never face the almost certain maladjustment of the child whose parents and other associates do not know that treatment of cleft palate and cleft lip has been reduced to an *almost* exact science.

Malformations of lips, noses, cheeks, extra-teeth – horribly out of place – receive the most exacting care. Before-and-after pictures of patients who have got "the works" often appear not to be the same persons – especially in the expression of the face and eyes. "Graduates" of the

Dr. Smith administering the battery of psychological tests.

clinic appear, most of them, to have come into their own, as indeed they have.

The Victor's Club

Dr. Cooper, to emphasize the meaning of "the works" of the Lancaster Cleft Palate Clinic, has organized the Victor's Club, consisting of members who have "graduated" from the clinic. If one did not know, it would be difficult to imagine that these Victors at one time were virtually unable to talk, for now they talk as if they could never get enough of speech. If they ever become egotistical, they have but to remove their speech appliances to be reminded of what they were — and still are, if some reverse miracle deprives them of what Dr. Cooper and the Lancaster Cleft Palate Clinic has done for them. Cooper and his associates feel that the patients have done as much for *them* spiritually, as they have done for the patients.

Dr. Cooper has received many honors during the past twelve years, in recognition of his rehabilitation work; each honor has given him more work to do. He occupies the first chair of Dental Institute School of Dentistry, University of Pennsylvania; lectures at other universities and colleges; supervises speech retraining at Franklin and Marshall College, and will go out of his way to help other dentists, anywhere, to found clinics patterned after his own.

Mrs. Cushman starting a youngster through "the works."

He wouldn't mind chapters of his Victor's Club scattered around the world, either. But it is work for the dedicated only, if Cooper's experiences are any criteria. However, he works much harder and longer than he needs to; the dentist logically initiates cleft palate work, then finds "dedicated" associates and trusts them to do their fair share.

It may never pay in money, but it pays off in satisfaction for the dentist with courage and vision to reach.

A patient hears herself as others hear her when spe
Genevieve M. Diller plays back her speech